

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF DELAWARE

HARLAN D. HAYMAN,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 00-515-SLR
	)	
LARRY G. MASSANARI, <sup>1</sup>	)	
Acting Commissioner of	)	
Social Security,	)	
	)	
Defendant.	)	

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Gary L. Smith, Esquire, Newark, Delaware. Counsel for Plaintiff.

Colm F. Connolly, United States Attorney, Ellen W. Slight, Assistant United States Attorney, United States Attorney's Office, Wilmington, Delaware. Counsel for Defendant. Of Counsel: James A. Winn, Regional Chief Counsel, David F. Chermol, Assistant Regional Counsel, Social Security Administration, Philadelphia, Pennsylvania.

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**MEMORANDUM OPINION**

Dated: October 1, 2001  
Wilmington, Delaware

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<sup>1</sup>Larry G. Massanari became the Acting Commissioner of Social Security, effective March 29, 2001, to succeed William A. Halter, who earlier succeeded Kenneth S. Apfel. Under Federal Rule of Civil Procedure 25(d)(1) and 42 U.S.C. § 405(g), Larry G. Massanari is automatically substituted as the defendant in this action.

**ROBINSON, Chief Judge**

**I. INTRODUCTION**

Plaintiff Harlan D. Hayman filed this action against defendant Larry G. Massanari,<sup>2</sup> the Commissioner of Social Security ("Commissioner") on May 24, 2000. (D.I. 1) Plaintiff seeks judicial review, pursuant to 42 U.S.C. § 405(g), of a decision by the Commissioner denying his claim for disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401-433. Currently before the court is plaintiff's motion for summary judgment (D.I. 10) and defendant's motion to remand (D.I. 14). For the reasons that follow, the court shall grant plaintiff's motion for summary judgment and deny defendant's motion to remand.

**II. BACKGROUND**

**A. Procedural History**

On June 25, 1997, plaintiff filed a claim for disability insurance benefits based on psychiatric problems, alleging an onset date of April 2, 1997. (D.I. 8 at 80-82) The claim was rejected initially and upon reconsideration. (Id. at 58, 59) On March 25, 1998, an administrative law judge ("ALJ") held a hearing at which plaintiff, plaintiff's wife, Colette Hayman, and

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<sup>2</sup>Larry G. Massanari became the Acting Commissioner of Social Security, effective March 29, 2001, to succeed William A. Halter, who earlier succeeded Kenneth S. Apfel. Under Federal Rule of Civil Procedure 25(d)(1) and 42 U.S.C. § 405(g), Larry G. Massanari is automatically substituted as the defendant in this action.

a vocational expert, Bruce Martin, testified. (Id. at 35-57)  
Plaintiff was represented by counsel. (Id. at 35) Medical  
evidence was submitted to supplement testimony given at the  
hearing. (Id. at 90-371)

On May 20, 1998, the ALJ issued a decision denying plaintiff  
benefits. (Id. at 13-28) In considering the entire record, the  
ALJ found the following:

1. The claimant met the disability insured status requirements of the [Social Security] Act on April 2, 1997, the date the claimant stated he became unable to work, and continues to meet them through December 31, 2001.
2. The claimant has not engaged in substantial gainful activity since April 2, 1997.
3. The medical evidence establishes that the claimant has severe paranoid schizophrenia, but that he does not have an impairment or combination of impairments listed in, or medically equal to, one listed in Appendix 1, Subpart P, Regulation No. 4.
4. The claimant's subjective complaints were neither fully credible nor fully corroborated by the objective medical evidence.
5. The claimant has the residual functional capacity to perform simple, repetitive tasks, in an environment involving no more than minimal interpersonal interaction and minimal levels of stress (20 C.F.R. § 404.1545).
6. The claimant's past relevant work as a custodian did not require the

performance of work related activities precluded by the above limitation(s) (20 C.F.R. § 404.1565).

7. The claimant's impairment does not prevent the claimant from performing his past relevant work.
8. The claimant was not under a "disability," as defined in the Social Security Act, at any time through the date of the decision (20 C.F.R. § 404.1520(e)).

(Id. at 23-4)

As part of his evaluation, the ALJ completed his own Psychiatric Review and Residual Capacity assessment, the results of which are incorporated into the decision document. (Id. at 13-28) The decision document does not refer to any consultation with a medical expert to assist the ALJ in completing his review and assessment, although it contains a generic statement that "the opinions of state agency medical and psychological consultants [will] be treated as expert opinion evidence from nonexamining sources." (Id. at 20.)

The ALJ's psychiatric review noted the presence of delusions or hallucinations and depression as evidence of psychotic features and deterioration in the plaintiff. (Id. at 25) In assessing plaintiff's functional limitations, the ALJ concluded plaintiff had moderate restrictions on his daily living activities, citing the treating physician's report and plaintiff's testimony that he did chores around the house and

went on errands. (Id. at 17) The ALJ found moderate limitations on plaintiff's ability to maintain social functioning. (Id. at 17) The ALJ referred to recent medical records reflecting "less paranoia" and "that the claimant is cooperative, friendly, and pleasant, with good eye contact." (Id.)

The ALJ also concluded that plaintiff possessed residual functional capacity to work at his most recent job as a custodian. In particular, the ALJ concluded that "the claimant retains the capacity to perform simple, repetitive tasks in an environment involving only minimal interpersonal interaction and low levels of stress." (Id. at 23) The ALJ stated that "his past custodial work would not be precluded by the above-stated limitations." (Id.)

In weighing the evidence, the ALJ did not consider the opinion of plaintiff's medical expert to be controlling because the ALJ found the opinion "to be inconsistent with other substantial medical and nonmedical evidence of record." (Id. at 22) The ALJ pointed to the differing ratings the physician gave to plaintiff's limitations on the insurance forms. (Id. (citing D.I. 8 at 369-70)) "[A]lthough Dr. Vigera [sic] noted severe limitations on the claimant's ability to perform varied or complex tasks, to interact with co-workers, and to respond to customary work pressures, he noted only moderate restrictions on the claimant's ability to accept supervision, perform simple or

repetitive tasks, or understand, remember and carry out tasks."

(Id.) The ALJ also concluded that CMHS "progress notes" from July 1997 through September 1997 were inconsistent with Dr. Vergara's opinion. The ALJ specifically cited notations that plaintiff was "neat and cooperative, with no loose associations or hallucinations, as well as relevant and coherent," that "[t]he claimant demonstrated no overt psychotic symptoms, his memory was intact, his intellectual functioning was average, and he was compliant with medications and clinic appointments," and that "the claimant was friendly, his mood was stable, he was alert, and he made good eye contact." (D.I. 8 at 22)

On May 12, 2000, the Appeals Council denied plaintiff's request for review, stating that the ALJ's decision "stands as the final decision of the Commissioner of Social Security."

(Id. at 5-6) The Council considered additional medical evidence and a brief submitted by plaintiff before rendering its decision.

(Id. at 372-464) Plaintiff now seeks review of this final decision before this court pursuant to 42 U.S.C. § 405(g).

#### **B. Facts Evinced at the Administrative Law Hearing**

Plaintiff was born on August 13, 1956. (Id. at 38) He lives with his wife and two stepchildren. (Id. at 41) He graduated from high school in 1975 and served in the United States Air Force from 1979 to 1985. (Id. at 38, 43, 45) After leaving the military, he worked at several different jobs and, in

1989, began working as a custodian at the University of Delaware. (Id. at 46; also see id. at 118) He continued at the custodial job through April 2, 1997, the date his alleged disability began. (Id. at 39)

Plaintiff testified that he began experiencing symptoms of schizophrenia during his military service, including hearing things and having thoughts that people were trying to kill him, but was not diagnosed until after his discharge. (Id. at 43-4) He stated that "[he] had a hard time getting to work, [he] wanted to run away from work," and that he left the service because he did not believe he was capable of working with a "top secret SCI clearance." (Id. at 44)

Plaintiff testified that he had been hospitalized in October 1987, March 1989, and December 1995 with a diagnosis of schizophrenia. (Id. at 30) In describing how his condition affected him and had affected him in the past, he testified to "seeing things and hearing things," "like people trying to kill me, things trying to kill me, birds talking, cars talking, electricity talking." (Id. at 40) He also claimed to hear music and "like things crawling in the tub" on a daily basis. (Id.) Other symptoms described include difficulty concentrating or thinking, thoughts of suicide, and a low energy level. (Id. at 40-1) He described not getting along with others and spending much of his time sleeping. (Id. at 40) He said he watched TV

but did not read, had no social life or hobbies, and would not go out of the house by himself. (Id. at 42) He claimed to do the laundry and occasionally cut the grass and said he could take care of his personal needs, such as bathing and dressing. (Id. at 41-2) Upon questioning about his daily routine, he described waking up at 6 a.m., taking his wife to work, napping until picking his wife up for lunch, picking her up after work, and then going to bed at 8 p.m. (Id. at 47) He said he spent so much time in bed because of "depression, I don't want to face hearing things and voices and seeing things and, I just cut it all, cut it out." (Id. at 47)

Plaintiff also testified that he did not think he was "mentally capable to work a full eight hour day" and that he had "bad days" two or three times a month when he could not anything at all, including bathing or shaving. (Id. at 48)

Plaintiff testified that he takes medication for his condition and is under medical treatment with Dr. Felix Vergara. (Id. at 41)

Plaintiff's wife, Colette Hayman, testified that plaintiff did not take her to work every day, just days when he had an appointment, and that she came home for lunch every day to check on him "to make sure he hasn't killed himself or something." (Id. at 49-50) She also stated that "[h]e sleeps a lot, I mean he's...always in bed, he doesn't want to go anywhere...even to

family...we don't go out, you know we don't do anything...it's like he's one of my kids kind of." (Id.)

In addition, Mrs. Hayman reported that plaintiff got agitated whenever he thought he had to go to work. (Id. at 51-2) "[I]f he had to go to work he would get real nervous, he wouldn't sleep well...he was pacing, he was smoking a lot more cigarettes...[h]e would just get really wierded [sic] out." (Id.)

In describing the circumstances of plaintiff's 1995 hospitalization at Rockford Center, his wife testified that she called the Crisis Intervention Service ("CIS") after plaintiff expressed paranoid thoughts to her, barricaded himself in his apartment, and stopped going to work. (Id. at 50-1) She testified that eventually he climbed out the apartment window and walked to New Jersey. (Id. at 51) The police searched for him and eventually he was found and hospitalized at Rockford Center. (Id. at 51) At the hearing, plaintiff testified that, after his discharge from Rockford Center, he went back to work parttime, but that his attendance record declined as he took "a lot of sick days off." (Id. at 46)

### **C. Vocational Evidence**

At the hearing, the ALJ called Bruce Martin ("Martin") as an independent vocational expert. Martin described plaintiff's past

relevant work as a custodian as "medium and unskilled work."

(Id. at 54)

After reviewing the impairments indicated by Dr. Vergara on assessments completed for plaintiff's insurance company (id. at 369-70), Martin stated:<sup>3</sup>

[G]iven these kinds of impairments . . . I think that such an individual would find it difficult to sustain competitive work activity because in all the interpersonal elements here there's either moderate to severe restriction and at any given moment such an individual could probably cope with day to day things, but whenever there's a conflict or tension there's the likelihood here of, of decompensation.

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<sup>3</sup>The ALJ also posed a hypothetical to Martin that included, in relevant part:

I want you to assume that I find that he has a diagnosis of schizophrenia, anxiety and depression. He can not perform under stressful situations, he can not have extensive contact with other people and he would have some difficulty performing varied tasks. Now, assume on one hand that I would find that the non-exertional impairments would exist in a curve with such frequency and severity so as to preclude sustained physical and mental activities on his part. (Off the record) (On the record) On the [other] hand assume I would find that the non-exertional impairments would be of a mild to moderate nature, not as severe as I've just described to you. Now, in light of that criteria and that alternative could he do any of the jobs indicated in the regulations?

(Id. at 54-5)

Martin answered, "From the standpoint of mild and moderate, Your Honor, his past relevant work." (Id. at 55) When the ALJ asked about the alternative hypothetical, Martin replied, "No, Your Honor, I don't think an individual with those kind of non-exertional restrictions would be able to maintain or sustain regular competitive work activity." (Id. at 55)

Because the court finds Dr. Vergara's opinion to have controlling weight, the court discounts the vocational expert's opinion with regard to the portion of the hypothetical posing a mild and moderate impairment.

(Id. at 56)

#### **D. Medical Evidence**

Plaintiff was admitted to Delaware State Hospital ("DSH") for the first time on October 13, 1987 because he felt "people [were] trying to eliminate him." (Id. at 144) Relatives reported that he had been experiencing psychiatric problems since his discharge from the military. (Id. at 144) He was diagnosed with "schizophreniform disorder" and placed on Haldol, and he was eventually discharged on November 2, 1987. (Id. at 145)

Plaintiff was readmitted to DSH on December 2, 1987 because of extreme paranoia and refusal to take his medication. (Id. at 148) He was diagnosed with "adjustment disorder with depressed mood schizophrenia, paranoid" and released on December 21, 1987. (Id. at 149)

Plaintiff was admitted to DSH for a third time on March 9, 1989 after waving a butcher knife in the presence of his girlfriend and saying "[s]omebody is going to come through the door and they're going to get this." (Id. at 151) After being stabilized with medication, he was released on March 23, 1989 with a diagnosis of "schizophrenic disorder, paranoid type." (Id. at 152)

Plaintiff received outpatient services from the New Castle County Community Mental Health Service ("CMHS") after his release

from DSH in 1989 through at least March 2000. CMHS records show that, through late 1994, he regularly met with clinic staff and received medication injections, and he was generally compliant with his treatment plan and doing well. (Id. at 297-337) In early 1995 he separated from his wife and decided to discontinue injections of Haldol administered by CMHS. (Id. at 290-5; Id. at 155) He switched to oral medication and soon afterward started missing appointments at CMHS. (Id. at 285-6)

On October 19, 1995, plaintiff was admitted to the Rockford Center due to an acute exacerbation of paranoid schizophrenia, apparently because he had stopped taking his medication. (Id. at 154) According to the Rockford Center discharge report, he began experiencing psychotic symptoms, including paranoid delusions. (Id. at 155) He had been missing from his home for three days before being found by police and admitted to Rockford Center. (Id. at 155) He had been picked up and released by police and a crisis intervention team in New Jersey, and a day later he was found by New Castle County police wandering near Delaware Memorial Bridge in a disoriented state. (Id. at 162-7)

After his release from Rockford, plaintiff began treatment with CMHS again, agreed to medication by injection, and went back to work. (Id. at 273-85) For several months he progressed well; by August 1996, however, he had to be put on an antidepressant medication. (Id. at 250-1) He initially felt better, but then

began feeling depressed again and missing work. (Id. at 245-7) A January 30, 1997 psychiatric re-evaluation by his physician, Dr. Felix Vergara, MD, indicated overall compliance with his treatment and no overt psychotic symptoms, but "episodes of depression and getting tired easily." (Id. at 240) A March 27, 1997 CMHS report indicates he was experiencing stress at work and was trying to transfer to "office work," which he apparently felt would not create any stress. (Id. at 236, 7) At an April 3, 1997 CMHS visit, plaintiff reported feeling depressed, tired, and stressed, and over the next several weeks, became increasingly anxious and had suicidal thoughts. (Id. at 225-230) He took sick leave from work beginning April 2, 1997. (Id. at 113, 369) On April 15, 1997, he contacted CIS with suicidal thoughts. (Id. at 160-1) He was admitted to the Diversion Program for three days of monitoring and treatment. (Id. at 168-187) The CIS screening form reported suicidal ideation, obsessive thoughts, and suspiciousness of others, as well as depression and anxiety. (Id. at 176, 179)

Later CMHS reports show that, although plaintiff was compliant with his treatment, he continued to experience anxiety and "jittery" feelings, and he worried he was becoming sick again. (Id. at 216-224) CMHS staff reported that he was friendly and cooperative on his visits there. (Id. at 216-224) CMHS reports completed after plaintiff had applied for social

security benefits in June 1997 show that he continued to be compliant with treatment, but still experienced anxiety, tension, poor concentration, and fear of crowds. (Id. at 201) Nevertheless, he was described by staff as being "quiet" and "friendly" (Id. at 209) and making "good eye contact, cooperative." (Id. at 201).

A Psychiatric Assessment Form completed by Natalie Volk, R.N., a CMHS nurse, in support of his social security benefits application, reported "neat appearance...cooperative," "no hallucination, relevant, coherent" thought processes, and "no overt psychotic symptoms," but also noted "inability to work due to stress and anxiety, mind racing, poor concentration." (Id. at 210-213) Her assessment of plaintiff's ability to perform mental work related functions was that "client cannot handle work related stress." (Id. at 213)

On July 22, 1997, Dr. Vergara completed an Attending Physician Statement (Id. at 367-8) and Request for Psychiatric Information form (Id. at 369-70) for plaintiff's long-term disability insurance carrier. In evaluating the extent of plaintiff's disability, Dr. Vergara indicated that plaintiff had "retrogressed" and was not able to work at his regular occupation; plaintiff was not able to work at any occupation; a possible return date to work was undetermined; and plaintiff was not a suitable candidate for rehabilitation services. (Id. at

368) The physician also stated that "when [plaintiff] is much improved, a less stressful job may be in order." (Id. at 368)

In Dr. Vergara's opinion, plaintiff had the following limitations in a routine work setting: severe limitation in responding appropriately to co-workers, responding to customary work pressures, performing complex tasks, and performing varied tasks; moderate limitation in responding appropriately to supervision, performing simple tasks, performing repetitive tasks, and understanding, carrying out, and remembering instructions. (Id. at 369) In addition, Dr. Vergara estimated plaintiff's degree of impairment to relate to other people as severe, his degree of restriction of daily activities as moderately severe, and his degree of deterioration in personal habits as mild.

In a January 1998 re-evaluation of plaintiff, Dr. Vergara reported plaintiff "has been depressed and unable to function... got anxious while working and felt people were talking about him, had auditory hallucinations for past two mos. or so [sic]...[and] is unable to work." (Id. at 364) In January 1999, the doctor reported continued compliance with treatment, but plaintiff "has not been able to work, unable to handle stress...has occasional auditory hallucinations." (Id. at 376) In the final psychiatric re-evaluation in the record, dated February 4, 2000, Dr. Vergara noted that plaintiff "has improved significantly [and] that his

psychotic symptoms are less...has occasional auditory hallucinations...is often uncomfortable around people...has not been able to work as he cannot handle stress." (Id. at 375)

As part of the benefits application and decision review process, plaintiff completed several self-assessments of his functional abilities and job history and duties. (Id. at 90-143) In an undated Function Report, he stated that he was "afraid of people, places and things," he "[found] it extremely hard to participate in any social or individual activities," and "sometimes it [sic] hard to control or get a hold of my mind...things are confusing...I have a difficult time trying to get comfortable for sleep." (Id. at 92-3) In an undated Disability Report, he listed Haldol (for paranoid schizophrenia), Zoloft (for depression), and Diphenhydram (for sleep) as his current medications. (Id. at 109)

On plaintiff's Reconsideration Disability Report, dated August 25, 1997, he reported daily suicidal thoughts and extreme depression, anxiety, and paranoia. (Id. at 136) He stated he was often unable to go outside by himself, limited himself to his bedroom, and had difficulty bathing, brushing his teeth, and shaving. (Id. at 138)

On a September 19, 1997 Daily Activities Questionnaire, plaintiff again described difficulty bathing, brushing teeth, and shaving, and also reported difficulty sleeping. (Id. at 132) He

described his daily routine as getting up, smoking, trying to clean up the kitchen, getting dressed, and watching TV. (Id. at 132) He reported going shopping once a week with his wife and leaving the house 3 or 4 times a week for short periods, usually with a family member. (Id. at 133) Although he indicated that he could drive, and he went out to doctors' appointments, the store, the gas station, and to pick up the children, he also reported needing a family member to go with him most of the time and sometimes having difficulty driving. (Id. at 133, 134) He claimed no hobbies and an inability to concentrate on reading material, but stated he could do the laundry, cut the grass, make his bed, and load the dishwasher. (Id. at 133) In addition, plaintiff reported never visiting family and not having any friends, and when people visited his home, he usually went to his bedroom. (Id. at 134) In describing how his condition kept him from working, he stated "just being around people put evil thoughts in my head making me run away to get as far away from the evil as I could...I see skin-heads, Nazis, KKK, which places fear in my heart...tried to pretend...made it difficult to get the job done." (Id. at 135) His request for a hearing listed two additional relevant medications besides those listed earlier: Amantadine (for side effects) and Hydroxyz (for depression). (Id. at 142)

Social Security Administration medical consultants completed the required Psychiatric Review Technique form and Mental Residual Capacity Assessment at the initial and reconsideration stages of the benefit review process. See 20 C.F.R. §§ 404.1520a(d)(2) and (e)(1); D.I. 8 at 188-200 (dated July 23, 1997); D.I. 8 at 338-350 (dated September 24, 1997).

The July 23, 1997 psychiatric review notes the presence of persistent psychotic features and deterioration evidenced by "emotional withdrawal and/or isolation." (D.I. 8 at 190) The "B" criteria functional limitation ratings indicate "moderate" difficulty in maintaining social functioning and one or two episodes of deterioration or decompensation in work or work-like settings, but only "slight" limitation on activities of daily living and "seldom" occurrences of deficiencies in concentration, persistence or pace. (Id. at 195)

On the corresponding Residual Capacity assessment, plaintiff was rated "markedly limited" in the ability to work in coordination with or proximity to others and in the ability to interact appropriately with the general public. (Id. at 197-8) He was rated "moderately limited" in the ability to maintain attention and concentration for extended periods, the ability to complete a normal workday and workweek and to perform at a consistent pace, and the ability to get along with coworkers or

peers without distracting them or exhibiting behavioral extremes.  
(Id.)

The September 24, 1997 psychiatric review indicated the presence of delusions or hallucinations and rated the "B" criteria the same as the July 23, 1997 review, except for finding a deficiency of concentration, persistence or pace occurred "often" instead of "seldom." (Id. at 338, 345) The September 24, 1997 Residual Function assessment also mirrored the July 23, 1997 assessment, except for rating the ability of plaintiff to respond appropriately to changes in the work setting and the ability to set realistic goals or make plans independently of others; the September evaluation was "moderately limited" in this category instead of "not significantly limited." (Id. at 347-8) The September 24 assessment also noted that plaintiff "appears able to perform low stress tasks involving minimal contact with others...[plaintiff] has had similar episodes in the past and he was able to return to work or keep working." (Id. at 349)

### **III. STANDARD OF REVIEW**

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, [are] conclusive," and the court will set aside the Commissioner's denial of plaintiff's claim only if it is "unsupported by substantial evidence." 42 U.S.C. § 405(g); 5 U.S.C. § 706(2)(E)

(1999); see Menswear Med. Ctr. v. Heckler, 806 F.2d 1185, 1190 (3d Cir. 1986). As the Supreme Court has held,

"substantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Accordingly, it "must do more than create a suspicion of the existence of the fact to be established.... It must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury."

Universal Camera Corp. v. NLRB, 340 U.S. 474, 477 (1951) (quoting NLRB v. Columbian Enameling & Stamping Co., 306 U.S. 292, 300 (1939)).

The Supreme Court also has embraced this standard as the appropriate standard for determining the availability of summary judgment pursuant to Fed. R. Civ. P. 56:

The inquiry performed is the threshold inquiry of determining whether there is the need for a trial – whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party.

Petitioners suggest, and we agree, that this standard mirrors the standard for a directed verdict under Federal Rule of Civil Procedure 50(a), which is that the trial judge must direct a verdict if, under the governing law, there can be but one reasonable conclusion as to the verdict. If reasonable minds could differ as to the import of the evidence, however, a verdict should not be directed.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250-51 (1986)

(internal citations omitted). Thus, in the context of judicial review under § 405(g),

"[a] single piece of evidence will not satisfy the substantiality test if the [Commissioner] ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence – particularly certain types of evidence (e.g., that offered by treating physicians) – or if it really constitutes not evidence but mere conclusion."

Brewster v. Heckler, 786 F.2d 581, 584 (3d Cir. 1986) (quoting Kent v. Schweiker, 710 F.2d 110, 114 (3d Cir. 1983)).

"Despite the deference due to administrative decisions in disability benefit cases, 'appellate courts retain a responsibility to scrutinize the entire record and to reverse or remand if the [Commissioner]'s decision is not supported by substantial evidence.'" Morales v. Apfel, 225 F.3d 310, 317 (3d Cir. 2000) (quoting Smith v. Califano, 637 F.2d 968, 970 (3d Cir. 1981)). "A district court, after reviewing the decision of the [Commissioner] may, under 42 U.S.C. 405(g) affirm, modify, or reverse the [Commissioner]'s decision with or without a remand to the [Commissioner] for rehearing." Podedworny v. Harris, 745 F.2d 210, 221 (3d Cir. 1984).

#### IV. DISCUSSION

##### A. Standards for Determining Disability

Congress enacted the Supplemental Security Income Program in 1972 "to assist 'individuals who have attained age 65 or are blind or disabled' by setting a guaranteed minimum income level for such persons." Sullivan v. Zebley, 493 U.S. 521, 524 (1990) (quoting 42 U.S.C. § 1381).

In Plummer v. Apfel, 186 F.3d 422 (3d Cir. 1999), the Third Circuit outlined the applicable statutory and regulatory process for determining whether a disability exists:

In order to establish a disability under the Social Security Act, a claimant must demonstrate there is some "medically determinable basis for an impairment that prevents him from engaging in any 'substantial gainful activity' for a statutory twelve-month period." A claimant is considered unable to engage in any substantial activity "only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy."

The Social Security Administration has promulgated regulations incorporating a sequential evaluation process for determining whether a claimant is under a disability. In step one, the Commissioner must determine whether the claimant is currently engaging in substantial gainful activity. If a claimant is found to be engaged in substantial activity, the disability claim will be denied. In step two, the Commissioner must determine whether the claimant is suffering from a severe impairment. If the claimant fails to show that her impairments are "severe", she is ineligible for disability benefits.

In step three, the Commissioner compares the medical evidence of the claimant's impairment to a list of impairments presumed severe enough to preclude any gainful work. If a claimant does not suffer from a listed impairment or its equivalent, the analysis proceeds to steps four and five. Step four requires the ALJ to consider whether the claimant retains the residual functional capacity to perform her past relevant work. The claimant bears the burden of demonstrating an inability to return to her past relevant work.

If the claimant is unable to resume her former occupation, the evaluation moves to the final step. At this stage, the burden of production shifts to the Commissioner, who must demonstrate the claimant is capable of performing other available work in order to deny a claim of disability. The ALJ must show there are other jobs existing in significant numbers in the national economy which the claimant can perform, consistent with her medical impairments, age, education, past work experience, and residual functional capacity. The ALJ must analyze the cumulative effect of all the claimant's impairments in determining whether she is capable of performing work and is not disabled. The ALJ will often seek the assistance of a vocational expert at this fifth step.

Id. at 427-8 (internal citations omitted).

For mental impairments, an additional regulatory process supplements the five-step process outlined above:

[This process] require[s] the hearing officer (and ALJ) to record the pertinent signs, symptoms, findings, functional limitations and effects of treatment contained in the case record, in order to determine if a mental impairment exists. If an impairment is found, the examiner must analyze whether certain medical findings relevant to a claimant's ability to work are present or absent. The examiner must then rate the degree of functional loss resulting from the impairment in certain areas deemed essential for work. [FN3] If the mental impairment is considered "severe", the

examiner must then determine if it meets a listed mental disorder. If the impairment is severe, but does not reach the level of a listed disorder, then the examiner must conduct a residual functional capacity assessment. At all adjudicative levels, a Psychiatric Review Treatment Form ("PRT form") must be completed. This form outlines the steps of the mental health evaluation in determining the degree of functional loss suffered by the claimant.

FN3. § 404.1520a(b)(3) provides for the examination of the degree of functional loss in four areas of function considered essential to work. These areas of activities are: daily living; social functioning; concentration, persistence, or pace; and deterioration or decompensation in work or work-like settings. The degree of functional loss is rated on a scale that ranges from no limitation to so severe the claimant cannot perform these work-related functions. This information is then detailed on a PRT form.

Id. at 428 (internal citations omitted).

The determination whether a claimant can perform other work may be based on the administrative rulemaking tables provided in the Department of Health and Human Services Regulations ("the grids"). See Jesurum v. Sec'y of Health & Human Servs., 48 F.3d 114, 117 (3d Cir. 1995) (citing Heckler v. Campbell, 461 U.S. 458, 468-70 (1983)). The grids require the ALJ to take into consideration the claimant's age, educational level, previous work experience, and residual functional capacity. See 20 C.F.R. § 404, subst. P, app. 2 (1999). If the claimant suffers from significant non-exertional limitations, such as pain or

psychological difficulties,<sup>4</sup> the ALJ must determine, based on the evidence in the record, whether these non-exertional limitations further limit the claimant's ability to work. See 20 C.F.R. § 404.1569a(c)-(d). If they do not, the grids may still be used. If, however, the claimant's non-exertional limitations are substantial, the ALJ must use the grids as a "framework" only. See 20 C.F.R. § 404, subst. P, app. 2, § 200(d)-(e). In such a case, or if a claimant's condition does not match the definition provided in the grids, determination of whether the claimant can work is ordinarily made with the assistance of a vocational specialist. See Santise v. Schweiker, 676 F.2d 925, 935 (3d Cir. 1982).

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<sup>4</sup>The regulations list the following examples of non-exertional limitations:

- (i) You have difficulty functioning because you are nervous, anxious, or depressed;
- (ii) You have difficulty maintaining attention or concentrating;
- (iii) You have difficulty understanding or remembering detailed instructions;
- (iv) You have difficulty in seeing or hearing;
- (v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or
- (vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

20 C.F.R. § 404.1569a(c).

## **B. Application of the Five-Step Test**

In the present case, the first three steps of the five-part test to determine whether a person is disabled are not at issue: (1) plaintiff is not working; (2) plaintiff's impairment has lasted more than twelve months; and (3) plaintiff does not have an impairment equal to or meeting one listed in the regulations.<sup>5</sup> The issues in this case concern the fourth and fifth steps: whether plaintiff retains the residual functional capacity to perform his past relevant work as a custodian or, if not, whether plaintiff can perform other work existing in the national economy. See Plummer, 186 F.3d at 428.

In the context of this five-step test, plaintiff had the burden of demonstrating that he was unable to engage in his past relevant work. Id. Here, plaintiff presented a strong prima facie case of his inability to return to his past relevant work through medical records, an expert medical opinion from his treating physician, and testimony at the oral hearing. Furthermore, in reviewing the treating physician's evaluation of plaintiff's limitations, the vocational expert agreed that

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<sup>5</sup>Plaintiff contends in a footnote that he would meet the requirements of Listing 12.03 if Dr. Vergara's opinion "were accepted" and, therefore, he should have been considered disabled at Step 3 of the evaluation process. (D.I. 11 at 7) Because the case can be resolved based on plaintiff's primary argument that he cannot perform past relevant work or any other work, the court does not discuss the merits of this argument.

plaintiff could not return to his past relevant work or to any other competitive work.

Under applicable regulations and controlling case law, "opinions of a claimant's treating physician are entitled to substantial and at times even controlling weight." Fargnoli v. Massanari, 247 F.3d 34, (3d Cir. 2001) (citing 20 C.F.R. § 404.1527(d)(2)). "Where a treating source's opinion on the nature and severity of claimant's impairment is 'well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in[the claimant's] case record,' it will be given 'controlling weight.'" Id. (quoting 20 C.F.R. § 404.1527(d)(2)) Treating physicians' reports should be accorded great weight, especially "when their opinions reflect expert judgment based on a continuing observation of the patient's condition over a prolonged period of time." Morales, 225 F.3d at 317 (quoting Rocco v. Heckler, 826 F.2d 1348, 1350 (3d Cir. 1987)). Where the opinion of a treating physician conflicts with that of a non-treating, non-examining physician, the ALJ may choose whom to credit but "cannot reject evidence for no reason or for the wrong reason." Morales, 225 F.3d at 317 (quoting Mason, 994 F.2d at 1066). In choosing to reject the treating physician's assessment, an ALJ may not make "speculative inferences from medical reports" and may reject "a treating physician's opinion

outright only on the basis of contradictory medical evidence" and not due to his or her own credibility judgments, speculation or lay opinion. Id. (quoting Plummer, 186 F.3d at 429). "The principle that an ALJ should not substitute his lay opinion for the medical opinion of experts is especially profound in a case involving a mental disability." Morales, 225 F.3d at 319.

Here, the ALJ refused to consider the Dr. Vergara's opinion controlling because he found the opinion "to be inconsistent with other substantial medical and nonmedical evidence of record." (D.I. 8 at 22) The court disagrees that the evidence cited by the ALJ is inconsistent with Dr. Vergara's opinion.

First, the ALJ pointed to the differing ratings the physician gave to plaintiff's limitations on the insurance forms. (Id. (citing D.I. 8 at 369-70)) The court points out that it cannot be "inconsistent" to rate entirely separate limitations differently, as the entire purpose of such an assessment form is to rate each limitation on its own merits.

Second, the ALJ concluded that CMHS "progress notes" from July 1997 through September 1997 were inconsistent with Dr. Vergara's opinion. The ALJ specifically cited notations that plaintiff was "neat and cooperative, with no loose associations or hallucinations, as well as relevant and coherent," that "[t]he claimant demonstrated no overt psychotic symptoms, his memory was intact, his intellectual functioning was average, and he was

compliant with medications and clinic appointments," and that "the claimant was friendly, his mood was stable, he was alert, and he made good eye contact." (D.I. 8 at 22)

The court finds that the ALJ impermissibly substituted his own lay opinion for that of the treating physician when he concluded that these notations were inconsistent with the physician's opinion that plaintiff was unable to withstand the stress of work. CMHS progress notes over the course of a decade reflect plaintiff's overall pleasant and cooperative demeanor, despite his long history of paranoid schizophrenia and episodes of regression. Dr. Vergara, who had treated plaintiff for several years at CMHS, surely was aware of these progress notes. The physician concluded that plaintiff was unable to work despite these observations of plaintiff's demeanor and his lack of overt psychotic symptoms. The ALJ offered no expert medical opinion that these observations created any inconsistency with Dr. Vergara's ultimate conclusion. Even if a lay opinion were appropriate here, the fact that plaintiff was pleasant and in control in a clinical, non-work setting does not necessarily reflect on his ability to function in a work environment. See Morales, 225 F.3d at 319 (observing that "the work environment is completely different from home or a mental health clinic" and concluding that observations that plaintiff was "stable and well-

controlled with medication" in a clinic setting did not support a medical conclusion that plaintiff could return to work).<sup>6</sup>

For the above reasons, as well as the lack of additional expert medical opinion at the hearing stage, the court concludes that defendant's medical evidence does not constitute substantial medical evidence inconsistent with the treating physician's opinion. As a result, the treating physician's opinion must be given controlling weight.<sup>7</sup>

The ALJ also considered nonmedical evidence in his ultimate conclusion that plaintiff retained the capacity to perform his past relevant work. The ALJ did not clearly state which nonmedical evidence he found persuasive in his decision, but in his recounting of the facts he cited plaintiff's testimony that

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<sup>6</sup>Although non-treating consultants rated plaintiff's limitations as less severe than Dr. Vergara rated them, their opinions receive less weight under applicable regulations and case law because they are non-treating experts. In addition, their opinions provide little supporting explanation and do not address the concerns the ALJ expressed about plaintiff's demeanor or lack of overt symptoms.

<sup>7</sup>The vocational expert who testified at the hearing concluded that plaintiff could not perform any competitive work if the treating physician's assessment were given controlling weight. "[G]iven these kinds of impairments . . . I think that such an individual would find it difficult to sustain competitive work activity." (D.I. 8 at 56) Because the court finds that the treating physician's opinion should have been given controlling weight, and the nonmedical evidence also supports plaintiff's lack of residual functional capacity, the court finds that the vocational evidence supports the conclusion that plaintiff has no residual capacity to perform his most recent relevant work and is unable to perform any other competitive work.

he could perform chores around the house and do errands (D.I. 8 at 22) and could take care of his personal needs (D.I. 8 at 20). Otherwise, the nonmedical facts cited in the ALJ's opinion support plaintiff's claim of disability. For example, both plaintiff and plaintiff's wife testified to his social isolation, his difficulty getting along with other people, and his depression and suicidal thoughts. (Id. at 20-2) After reviewing all the nonmedical evidence on the record, the court concludes that the weight of the evidence does not support the ALJ's finding of residual functional capacity.

**C. Substantial Evidence in the Record Supports Award of Benefits to Plaintiff**

The decision to award benefits directly rather than remanding to the Commissioner is warranted when "the administrative record of the case has been fully developed and when substantial evidence in the record as a whole indicates that the claimant is disabled and entitled to benefits." Podedworny, 745 F.2d t 221. In particular, "where further administrative proceedings would simply prolong the claimant's ultimate receipt of benefits," a direct award, rather than remand, is especially appropriate. See Id. at 223.

A direct award of benefits is warranted here because the administrative record of the case has been fully developed and substantial evidence in the record as a whole indicates that plaintiff is disabled and entitled to benefits. Remand to the

agency would serve no purpose because the Commissioner has already had ample opportunity to develop and present medical evidence to counter the strong prima facie case presented by plaintiff. See, e.g., Allen v. Bowen, 881 F.2d 37, 44 (3d Cir. 1989) ("Where . . . the claimant established a prima facie case of entitlement, the record was fully developed, and there is no good cause for the Secretary's failure to adduce all the relevant evidence at the prior proceeding, we see no reason to remand for further fact finding."); Woody v. Sec'y of Health and Human Servs., 859 F.2d 1156, 1162-3 (3d Cir. 1988) (awarding benefits directly rather than remanding to agency where ALJ failed to rebut plaintiff's "well-developed prima facie case"). The ALJ also explained how he weighed the evidence he used as a basis of his decision, so there is no basis for remand for further explanation of his decision.

Plaintiff carried his burden of proof to establish he could not work at his past relevant work, and defendant failed to rebut plaintiff's case with substantial, countervailing expert evidence or other evidence. In addition, vocational evidence on the record supports a finding that plaintiff cannot perform any other work. As a result, substantial evidence supports a finding of disability and an award of benefits rather than remand to the agency.

## **V. CONCLUSION**

For the reasons stated above, the court finds that defendant lacked substantial evidence to support a denial of benefits. In addition, the court finds that the administrative record of the case has been fully developed and substantial evidence indicates plaintiff is disabled and entitled to benefits. Accordingly, the court shall grant plaintiff's motion for summary judgment and deny defendant's motion to remand. An appropriate order shall issue.

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF DELAWARE

HARLAN D. HAYMAN,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 00-515-SLR
	)	
LARRY G. MASSANARI,	)	
Acting Commissioner of	)	
Social Security,	)	
	)	
Defendant.	)	

O R D E R

At Wilmington this 1st day of October, 2001, consistent with the memorandum opinion issued this same day;

IT IS ORDERED that:

1. Plaintiff's motion for summary judgment (D.I. 10) is granted.
2. Defendant's motion for remand (D.I. 14) is denied.
3. The clerk is directed to enter judgment in favor of plaintiff and against defendant.

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United States District Judge